

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038612</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Waterford, The</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>7445 N. Sheridan Rd.</u> <u>Chicago</u> <u>60626</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(773) 338-3300</u> Fax # <u>(773) 338-5868</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Garry S. Chankin, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>363853042001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>07/01/82</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 04/07/03

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>51</u>	Skilled (SNF)	<u>47</u>	<u>17,539</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>94</u>	<u>34,694</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>149</u>	TOTALS	<u>141</u>	<u>52,233</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,971</u>	<u>521</u>	<u>1,860</u>	<u>11,352</u>	8
9	SNF/PED					9
10	ICF	<u>26,261</u>	<u>1,275</u>		<u>27,536</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,232</u>	<u>1,796</u>	<u>1,860</u>	<u>38,888</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.45%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/82

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 07/01/82 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 24 and days of care provided 1,673Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Waterford, The

0038612

Report Period Beginning: 01/01/03

Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	168,570	16,776	4,900	190,246		190,246		190,246			1
2	Food Purchase		155,871		155,871	(24,528)	131,343	(72)	131,271			2
3	Housekeeping	75,122	14,444		89,566		89,566		89,566			3
4	Laundry	41,612	7,024		48,636		48,636		48,636			4
5	Heat and Other Utilities			85,754	85,754		85,754		85,754			5
6	Maintenance	18,438		101,537	119,975		119,975	(56,604)	63,371			6
7	Other (specify):*											7
8	TOTAL General Services	303,742	194,115	192,191	690,048	(24,528)	665,520	(56,676)	608,844			8
	B. Health Care and Programs											
9	Medical Director			31,300	31,300		31,300		31,300			9
10	Nursing and Medical Records	897,033	31,747	402,989	1,331,769		1,331,769	(5,934)	1,325,835			10
10a	Therapy	46,636		4,361	50,997		50,997		50,997			10a
11	Activities	77,100	2,639	4,180	83,919		83,919		83,919			11
12	Social Services	98,382		3,383	101,765		101,765		101,765			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,119,151	34,386	446,213	1,599,750		1,599,750	(5,934)	1,593,816			16
	C. General Administration											
17	Administrative	106,644		230,860	337,504		337,504	(3,539)	333,965			17
18	Directors Fees											18
19	Professional Services			70,256	70,256		70,256	(2,290)	67,966			19
20	Dues, Fees, Subscriptions & Promotions			28,107	28,107		28,107	(9,826)	18,281			20
21	Clerical & General Office Expenses	25,004	2,775	166,707	194,486		194,486	(117,139)	77,347			21
22	Employee Benefits & Payroll Taxes			234,352	234,352	24,528	258,880		258,880			22
23	Inservice Training & Education											23
24	Travel and Seminar			943	943		943		943			24
25	Other Admin. Staff Transportation			865	865		865		865			25
26	Insurance-Prop.Liab.Malpractice			96,952	96,952		96,952		96,952			26
27	Other (specify):*							232	232			27
28	TOTAL General Administration	131,648	2,775	829,042	963,465	24,528	987,993	(132,562)	855,431			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,554,541	231,276	1,467,446	3,253,263		3,253,263	(195,172)	3,058,091			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Waterford, The

#0038612

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			75,351	75,351		75,351	9,760	85,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,132	11,132		11,132	122,003	133,135			32
33	Real Estate Taxes							169,473	169,473			33
34	Rent-Facility & Grounds			604,552	604,552		604,552	(604,552)				34
35	Rent-Equipment & Vehicles			4,883	4,883		4,883		4,883			35
36	Other (specify):*							5,858	5,858			36
37	TOTAL Ownership			695,918	695,918		695,918	(297,458)	398,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,975	108,194	188,169		188,169		188,169			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,350	78,350		78,350		78,350			42
43	Other (specify):*			20,876	20,876		20,876	(20,876)				43
44	TOTAL Special Cost Centers		79,975	207,420	287,395		287,395	(20,876)	266,519			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,554,541	311,251	2,370,784	4,236,576		4,236,576	(513,506)	3,723,070			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Waterford, The

0038612

Report Period Beginning:

01/01/03

Ending:

12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,913	30		9
10	Interest and Other Investment Income	(4,430)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,255)	21		18
19	Entertainment	(745)	20		19
20	Contributions	(1,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(108,492)	21		24
25	Fund Raising, Advertising and Promotional	(3,938)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,387)	20		28
29	Other-Attach Schedule	(95,087)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (217,993)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(295,513)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (295,513)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (513,506)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Waterford, The

ID# 0038612

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Miscellaneous Income	\$ (340)	21 1
2	Resident's Expense	(340)	21 2
3	Marketing Expense	(20,876)	43 3
4	Bank Charges	(1,720)	21 4
5	R.C.L.C. - CORP	(2,250)	20 5
6	Prior Period Legal	(200)	19 6
7	Capitalized R&M	(56,604)	06 7
8	Non-allowable Legal (Missing Invoices)	(2,000)	19 8
9	Building Company - Professional Fees	(2,000)	19 9
10	Non-allowable Interest-Shareholder's Loan	(7,600)	32 10
11			11
12			12
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95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(55,087)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Waterford, The

0038612

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(72)											(72)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(56,604)											(56,604)	6
7	Other (specify):*													7
8	TOTAL General Services	(56,676)											(56,676)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(5,934)									(5,934)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs			(5,934)									(5,934)	16
	C. General Administration													
17	Administrative				(3,539)								(3,539)	17
18	Directors Fees													18
19	Professional Services	(4,290)	2,000										(2,290)	19
20	Fees, Subscriptions & Promotions	(9,826)											(9,826)	20
21	Clerical & General Office Expenses	(117,139)											(117,139)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*				232								232	27
28	TOTAL General Administration	(131,255)	2,000		(3,307)								(132,562)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(187,931)	2,000	(5,934)	(3,307)								(195,172)	29

Summary B

12/31/03

[illegible]

Facility Name & ID Number Waterford, The# 0038612

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 604,552	Deauville Healthcare	100.00%	\$	(604,552)	1
2	V	19 Professional Fees		Deauville Healthcare	100.00%	2,000	2,000	2
3	V	33 Real Estate Taxes		Deauville Healthcare	100.00%	169,473	169,473	3
4	V	30 Depreciation		Deauville Healthcare	100.00%	6,847	6,847	4
5	V	32 Interest Expense		Deauville Healthcare	100.00%	134,102	134,102	5
6	V	36 Amortization		Deauville Healthcare	100.00%	5,858	5,858	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 604,552			\$ 318,280	\$ * (286,272)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Outside Services	\$ 254,400	John's Nursing Temps	100.00%	\$ 248,466	\$ (5,934)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 254,400			\$ 248,466	\$ * (5,934)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The

0038612

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 SALARY - STAN ARON	\$	PRO HEALTH CARE, INC.	100.00%	\$ 2,941	\$ 2,941
16	V	27 PAYROLL TAXES				232	232
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V	17 MANAGEMENT FEES	6,480				(6,480)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,480			\$ 3,173	\$ * (3,307)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The# 0038612Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dan Shabat	Owner	Administrative	18.05%	See Attached	35.00	58.33%	Sal/Mgmt.	\$ 259,696	17-1,7	1
2	Stan Aron	Owner	Administrative	7.22%	See Attached	3.00	4.61%	Alloc.ProHea	2,941	17-7	2
3	Ari Shabat	Relative	Administrative	None	See Attached	20.00	50.00%	Salary	23,196	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 285,833		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization John's Nursing Temps
 Street Address 7514 N. Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847-982-1195
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Outside Services	Direct Allocation	1	\$ 248,466	\$		248,466	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 248,466	\$		\$ 248,466	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PRO HEALTH CARE, INC. C/O FR&R
 Street Address 111 PFINGSTEN ROAD
 City / State / Zip Code DEERFIELD, IL 60115
 Phone Number (847)236-1111
 Fax Number (847)236-1155

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	\$ 50,000	\$ 50,000	3	\$ 2,941	1
27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	3,935		3	232	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 53,935	\$ 50,000		\$ 3,173	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The # 0038612 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Royal Gardens		X	Mortgage	\$10,458.00	10/01/90	\$ 2,361,650	\$ 646,080	08/01/11	11.00%	\$ 73,707	1	
2	Mid North Financial		X	Mortgage				450,664			60,394	2	
3	Lexus Financial		X	Auto Loan	\$799.00	01/01/02		14,806	08/01/05	7.90%	3,463	3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Shareholder Loan	X		Working Capital	None	11/01/92	500,000	500,000				6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$11,257.00		\$ 2,861,650	\$ 1,611,550			\$ 137,564	9	
	B. Non-Facility Related*												
10												10	
11	Interest Income										(4,430)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,430)	14	
15	TOTALS (line 9+line14)						\$ 2,861,650	\$ 1,611,550			\$ 133,134	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Waterford, The COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038612

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-29-308-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>167,558.75</u>	\$ <u>167,558.75</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>167,558.75</u>	\$ <u>167,558.75</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Waterford, The	COUNTY	Cook
---------------	----------------	--------	------

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Index Number	Property Description	Total Tax	

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Page 10B

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 23,216

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 3

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 196,188	1
2					2
3	TOTALS			\$ 196,188	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various	1993		63,831		20	3,192	3,192	32,222
10	Various	1994		33,446		20	1,672	1,672	16,159
11	Various	1995		40,581		20	2,029	2,029	17,904
12	Various	1996		19,396		20	971	(971)	7,457
13	Various	1997		99,588		20	4,980	4,980	32,933
14	Various	1998		26,433		20	1,323	1,323	7,492
15	Various	1999		80,052		20	4,005	4,005	17,520
16							-		-
17							-		-
18							-		-
19							-		-
20							-		-
21							-		-
22							-		-
23							-		-
24							-		-
25							-		-
26							-		-
27							-		-
28							-		-
29							-		-
30							-		-
31							-		-
32							-		-
33							-		-
34							-		-
35							-		-
36							-		-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,463,351	6,847		8,688	1,841	2,421,374	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			18,618			(18,618)		68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 2,826,678	\$ 25,465		\$ 26,860	\$ (547)	\$ 2,553,061	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,826,678	\$ 25,465		\$ 26,860	\$ 1,395	\$ 2,553,061	1
2	Corridor Railings	2000	5,913		20	296	296	961	2
3	Corridor Railings	2000	11,473		20	574	574	1,769	3
4	Wardrobes	2000	16,660		20	833	833	2,777	4
5	Hot Water Heater	2000	3,860		20	193	193	756	5
6	Door	2000	806		20	40	40	158	6
7	Doors	2000	1,500		20	75	75	294	7
8	Light Fixtures	2000	875		20	44	44	169	8
9	Generator Duct	2000	750		20	38	38	145	9
10	Boiler Rm Insulation	2000	3,000		20	150	150	563	10
11	Light Fixtures	2000	2,250		20	113	113	413	11
12	Keypad Alarm	2000	891		20	45	45	160	12
13	Generator Duct	2000	750		20	38	38	145	13
14	Boiler Room Piping	2000	2,000		20	100	100	392	14
15	Toilet	2000	525		20	26	26	83	15
16	Elevator Motor	2000	1,065		20	53	53	187	16
17	Window Treatment	2000	9,455		20	473	473	1,892	17
18	Curtains	2000	4,908		20	245	245	981	18
19	Painting	2000	574		20	29	29	110	19
20	Carpeting	2000	601		20	30	30	115	20
21	Painting	2000	916		20	46	46	173	21
22	Painting	2000	179		20	9	9	34	22
23	Decorating	2000	308		20	15	15	57	23
24	Painting	2000	90		20	5	5	17	24
25	Carpet Border	2000	44		20	2	2	7	25
26	Decorating	2000	400		20	20	20	72	26
27	Carpet Border	2000	46		20	2	2	8	27
28	Painting	2000	226		20	11	11	40	28
29	Decorating	2000	100		20	5	5	18	29
30	Painting	2000	574		20	29	29	101	30
31	Wall-Base Covering	2000	305		20	15	15	54	31
32	Painting	2000	690		20	35	35	122	32
33	Painting	2000	650		20	33	33	115	33
34	TOTAL (lines 1 thru 33)		\$ 2,899,062	\$ 25,465		\$ 30,482	\$ 5,017	\$ 2,565,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,899,062	\$ 25,465		\$ 30,482	\$ 5,017	\$ 2,565,949	1
2	Painting	2000	800		20	40	40	140	2
3	Wall-Base Covering	2000	305		20	15	15	52	3
4	Tile	2000	7,764		20	388	388	1,326	4
5	Flooring	2000	1,408		20	70	70	240	5
6	Painting	2000	600		20	30	30	105	6
7	Wall Cove Base	2000	113		20	6	6	19	7
8	Painting	2000	400		20	20	20	67	8
9	Wallpaper	2000	1,680		20	84	84	273	9
10	Wallpaper	2000	1,995		20	100	100	308	10
11	Painting	2000	217		20	11	11	34	11
12	Tile	2001	2,239		20	112	112	261	12
13	Front Awning	2001	2,710		20	474	474	1,525	13
14	Steel Frame-Dayroom	2001	8,833		20	442	442	994	14
15	Reception Desk	2001	8,378		20	419	419	908	15
16	Fence	2001	595		20	30	30	76	16
17	Sign	2001	1,794		20	90	90	209	17
18	Shelves And Posts	2001	2,317		20	116	116	270	18
19	Dryer Motor	2001	657		20	33	33	97	19
20	Hydraulic Pump	2001	986		20	49	49	138	20
21	Electric Line & Motor	2001	980		20	49	49	137	21
22	Expansion Valve	2001	966		20	48	48	123	22
23	Duct Fitting	2001	1,321		20	66	66	168	23
24	Condenser Fan	2001	870		20	44	44	107	24
25	Blower Bearing	2001	968		20	48	48	119	25
26	Glass Windows	2001	800		20	40	40	93	26
27	Bearing Assembly	2001	639		20	32	32	72	27
28	Pump Motor	2001	699		20	35	35	73	28
29	Sign	2001	2,285		20	114	114	238	29
30	Sump Pump	2001	625		20	31	31	70	30
31	Locks & Elevator System	2001	5,566		20	278	278	707	31
32	Hot Water Line	2001	4,500		20	225	225	469	32
33	Refinish Elevator Doors	2001	542		20	27	27	59	33
34	TOTAL (lines 1 thru 33)		\$ 2,963,614	\$ 25,465		\$ 34,048	\$ 8,583	\$ 2,575,426	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward		\$ 2,963,614	\$ 25,465		\$ 34,048	\$ 8,583	\$ 2,575,426		1
2	Painting	2001	1,000		20	50	50	108		2
3	Wallcover & Paint	2001	3,744		20	187	187	421		3
4	Tile	2001	5,239		20	262	262	611		4
5	Lobby Carpet/Wallcovering	2002	28,111		20	2,811	2,811	5,622		5
6	Window Treatments	2002	3,361		20	336	336	672		6
7	Wall & Doors	2002	2,800		20	280	280	327		7
8	Covers-Fan Units	2002	3,825		20	383	383	701		8
9	Radiator Covers	2002	7,449		20	745	745	1,242		9
10	Floor Repairs	2002	801		20	40	40	80		10
11	Sump Pumps	2003	2,989		20	149	149	149		11
12	Plumbing	2003	2,750		20	138	138	138		12
13	Hvac	2003	5,862		20	269	269	269		13
14	Test Duct Detectors	2003	4,485		20	187	187	187		14
15	Doors	2003	715		20	30	30	30		15
16	Hvac	2003	4,826		20	181	181	181		16
17	Hvac	2003	2,987		20	112	112	112		17
18	Hvac	2003	3,047		20	114	114	114		18
19	Hvac	2003	1,763		20	51	51	51		19
20	Hvac	2003	2,403		20	70	70	70		20
21	Flooring	2003	1,837		20	54	54	54		21
22	Electric Line	2003	1,750		20	44	44	44		22
23	Elevator Repair	2003	1,300		20	33	33	33		23
24	Electric Line & Outlets	2003	1,849		20	46	46	46		24
25	Bathroom Fixtures	2003	1,500		20	38	38	38		25
26	Painting & Cabinets	2003	450		20	11	11	11		26
27	Hvac	2003	1,695		20	42	42	42		27
28	Bathroom Fixtures	2003	500		20	10	10	10		28
29	Bathroom Remodeling	2003	1,000		20	17	17	17		29
30	Electric Line & Breaker	2003	525		20	9	9	9		30
31	Elevator Repair	2003	893		20	15	15	15		31
32	Bathroom Fixtures	2003	500		20	8	8	8		32
33	Hvac	2003	1,292		20	22	22	22		33
34	TOTAL (lines 1 thru 33)		\$ 3,066,862	\$ 25,465		\$ 40,792	\$ 15,327	\$ 2,586,860		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 3,066,862	\$ 25,465		\$ 40,792	\$ 15,327	\$ 2,586,860	1
2 Freezer Repair	2003	996		20	17	17	17	2
3 Tuckpointing	2003	1,000		20	13	13	13	3
4 Wallcovering	2003	1,400		20	18	18	18	4
5 Faucets	2003	660		20	6	6	6	5
6 Fire System Repair	2003	748		20	6	6	6	6
7 Janitor'S Sink & Faucet	2003	750		20	6	6	6	7
8 Elevator Repair	2003	1,025		20	4	4	4	8
9 Elevator Repair	2003	1,952		20	8	8	8	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,075,393	\$ 25,465		\$ 40,870	\$ 15,405	\$ 2,586,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	141	1994		\$ 2,183,550	\$		\$	\$	\$ 2,183,550	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Deauville Healthcare Center		1982	3,174					3,174	9
10	Deauville Healthcare Center		1983	22,098					22,098	10
11	Deauville Healthcare Center		1984	78,473					78,473	11
12	Deauville Healthcare Center		1985	65,697	3,440		3,458	(18)	63,142	12
13	Deauville Healthcare Center		1986	11,600	487		611	124	10,736	13
14	Deauville Healthcare Center		1987	17,548	557		557		9,191	14
15	Deauville Healthcare Center		1990	16,762	532		838	306	11,313	15
16	Deauville Healthcare Center		1991	36,643	1,163		1,833	670	23,753	16
17	Deauville Healthcare Center		1992	27,806	668		1,391	723	15,944	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

***Total beds on this schedule must agree with page 2.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)			\$ 2,463,351	\$ 6,847		\$ 8,688	\$ 1,805	\$ 2,421,374	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 285,081	\$ 33,408	\$ 28,337	\$ (5,071)	10	\$ 154,785	71
72	Current Year Purchases	1,155		43	43	10	43	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 286,236	\$ 33,408	\$ 28,380	\$ (5,028)		\$ 154,828	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		LEXUS	2002	\$ 30,000	\$ 23,325	\$ 15,861	\$ (7,464)	5	\$ 25,191	76
77										77
78										78
79										79
80	TOTALS			\$ 30,000	\$ 23,325	\$ 15,861	\$ (7,464)		\$ 25,191	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,587,817	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82,198	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,111	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,913	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,766,957	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	EXCESS AUTO COST - 1996	\$ 32,200	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 32,200	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 4,883

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 33,357	\$		\$ 33,357	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,690			11,690	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			63,147			63,147	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				65,597		65,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						14,378		14,378	13
14	TOTAL			\$		\$ 108,194	\$ 79,975		\$ 188,169	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 284,943	\$ 284,943	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	658,429	658,429	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,586	33,586	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		617,826	8
9	Other(specify): See Attached Schedule	471,451	710,131	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,448,409	\$ 2,304,915	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,934	13
14	Buildings, at Historical Cost		2,211,665	14
15	Leasehold Improvements, at Historical Cost	303,067	554,009	15
16	Equipment, at Historical Cost	360,393	785,115	16
17	Accumulated Depreciation (book methods)	(362,890)	(3,189,819)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		11,740	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 300,570	\$ 568,644	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,748,979	\$ 2,873,559	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 180,566	\$ 180,566	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	522,879	814,968	29
30	Accrued Salaries Payable	153,818	153,818	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,606	1,606	31
32	Accrued Real Estate Taxes(Sch.IX-B)		172,586	32
33	Accrued Interest Payable		10,053	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	693	693	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	929,435	467,600	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,788,997	\$ 1,801,890	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(8,073)	796,582	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	7,669	7,669	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (404)	\$ 804,251	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,788,593	\$ 2,606,141	46
47	TOTAL EQUITY (page 18, line 24)	\$ (39,614)	\$ 267,418	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,748,979	\$ 2,873,559	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 206,765	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 206,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(246,379)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (246,379)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (39,614)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,943,696	1
2	Discounts and Allowances for all Levels	(160,256)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,783,440	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,639	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,639	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,390	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,699	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,892	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,981	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,430	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,430	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	707	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 707	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,990,197	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	690,048	31
32	Health Care	1,599,750	32
33	General Administration	963,465	33
	B. Capital Expense		
34	Ownership	695,918	34
	C. Ancillary Expense		
35	Special Cost Centers	209,045	35
36	Provider Participation Fee	78,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,236,576	40
41	Income before Income Taxes (line 30 minus line 40)**	(246,379)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (246,379)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Waterford, The**# **0038612**Report Period Beginning: **01/01/03**

Ending:

12/31/03**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,506	1,954	\$ 45,048	\$ 23.05	1
2	Assistant Director of Nursing	1,746	1,842	49,726	27.00	2
3	Registered Nurses	6,558	7,744	131,196	16.94	3
4	Licensed Practical Nurses	8,957	9,588	181,173	18.90	4
5	Nurse Aides & Orderlies	51,754	56,870	469,821	8.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,696	4,229	46,636	11.03	8
9	Activity Director					9
10	Activity Assistants	7,721	9,211	77,100	8.37	10
11	Social Service Workers	5,666	6,255	98,382	15.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,407	19,480	168,570	8.65	15
16	Dishwashers					16
17	Maintenance Workers	2,056	2,125	18,438	8.68	17
18	Housekeepers	8,622	9,652	75,122	7.78	18
19	Laundry	5,468	5,882	41,612	7.07	19
20	Administrator	1,880	2,080	48,132	23.14	20
21	Assistant Administrator					21
22	Other Administrative	2,860	2,860	58,512	20.46	22
23	Office Manager					23
24	Clerical	2,584	2,688	25,004	9.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,856	1,968	20,069	10.20	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	130,337	144,428	\$ 1,554,541 *	\$ 10.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,900	01-03	35
36	Medical Director	Monthly	31,300	09-03	36
37	Medical Records Consultant	Monthly	2,064	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	39	1,928	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	76	4,180	11-03	44
45	Social Service Consultant	97	3,383	12-03	45
46	Other(specify)				46
47	<u>Rehab Consultant</u>	64	2,433	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 50,188		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	11,455	\$ 400,925	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	11,455	\$ 400,925		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries						D. Employee Benefits and Payroll Taxes						F. Dues, Fees, Subscriptions and Promotions					
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount								
Kathy Donahue	Administrator	0%	\$ 48,132	Workers' Compensation Insurance	\$ 29,462	IDPH License Fee	\$ _____										
Daniel Shabat	Administrative	18.05%	35,316	Unemployment Compensation Insurance	14,681	Advertising: Employee Recruitment	6,339										
Ari Shabat	Administrative	0%	23,196	FICA Taxes	118,922	Health Care Worker Background Check <small>(Indicate # of checks performed <u>Zero</u>)</small>	_____										
				Employee Health Insurance	50,682	Advertising/Yellow Page Licenses	5,325 / 5,069										
				Employee Meals	24,528	ICLTC Dues	8,493										
				Illinois Municipal Retirement Fund (IMRF)*		ICLTC COPE	(2,256)										
				City Tax	5,304	Other Dues	636										
				Pension	7,637	Less: Public Relations Expense	(_____)										
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,644	Other Benefits	7,664	Non-allowable advertising	(3,938)										
B. Administrative - Other						Yellow page advertising	(1,387)										
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,281										
Management Fees-Dan Shabat			\$ 224,380														
Management Fees Pro Health			6,480														
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 258,880	G. Schedule of Travel and Seminar**											
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 230,860	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		Description	Amount										
C. Professional Services				Description	Line #	Amount	Out-of-State Travel	\$ _____									
Vendor/Payee	Type		Amount				In-State Travel	_____									
Frost, Ruttenberg & Rothblatt	Accounting		\$ 47,487				Seminar Expense	943									
See Attached	Legal		4,320				Entertainment Expense	(_____)									
Personnel Planners	Unemployment Conslt.		720				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 943									
Econocare Care	Purchasing Consultant		2,091														
Senior Living Systems	Computer Consultant		15,638														
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 70,256	TOTAL		\$ _____											

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Waterford, The

STATE OF ILLINOIS

0038612

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Nurse's Aides
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$8,493
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,831 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Deauville Healthcare Center, Lic#38612, 11/01/1992
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 78,350
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,528 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.